MHCC Nursing Home Background Paper

January 30, 2018

Profile of Maryland Nursing Homes:

A Maryland nursing home, defined as a health care facility in accordance with COMAR 10.07.02, is licensed as a comprehensive care facility (CCF) and "admits residents requiring medical services and nursing services rendered by or under the supervision of a registered nurse, who: 1) are advanced in age; or 2) have a disease or disability."[1] Nursing homes are licensed under these Maryland regulations by the Office of Health Care Quality (OHCQ). Furthermore, OHCQ is the State Agency responsible for assuring that nursing homes must also meet federal Conditions of Participation to obtain certification in the Medicare and Medicaid programs.

As of January 2018, there were 229 Maryland nursing homes, with a total of 28,452 beds. Of the total beds, 27,329, or 96 percent, are licensed and available for patient care. Included in the total beds, there are 340 Certificate of Need (CON)-approved beds, 336 waiver beds, and 447 temporarily delicensed beds.

Licensed nursing home beds have received a CCF license from OHCQ under COMAR 10.07.02. The beds at such facilities have either received a CON, or have been grandfathered into the program because they pre-dated the CON program. Some licensed beds in facilities have been obtained through acquisition.

CON-approved beds have received a CON from the Maryland Health Care Commission (MHCC) by meeting all of the appropriate standards under COMAR 10.24.01 (CON regulations), as well as COMAR 10.24.08 (Nursing Home Chapter of the State Health Plan). CON-approved beds have been approved for future development, but are not yet licensed.

Waiver beds are those approved for establishment under COMAR 10.24.01.02A (3) a. Waiver beds generally involve an increase or decrease in capacity of 10 beds or 10 percent (whichever is less); these beds are also not yet licensed for patient care.

Temporarily delicensed beds have been authorized by the Commission to remain "off-line" (out of service), usually for a period of one year, pending plans to delicense the beds permanently, re-implement, or transfer ownership of the bed capacity. While these beds are removed by OHCQ from the license for that facility, they are maintained in the Commission's inventory, pending plans to delicense or otherwise use the beds. The rules regarding temporary delicensure were established by the Commission in 2001 and are found in COMAR 10.24.01.03C.

Some nursing home beds are located in **Continuing Care Retirement Communities** (CCRCs). Such beds have either received a CON, been grandfathered (preceded CON), or received an exclusion from CON under COMAR 10.24.01.03K. According to these regulations, the beds

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[1] COMAR 10.07.02 draft regulations, 11/14/2016.

obtained under this exclusion may not exceed the ratio of one bed for every five independent living units (or 20 percent) for those communities with 300 or more independent living units. For communities with fewer than 300 independent living units, the ratio is up to 24 percent. These beds receive an exclusion because they are occupied by residents of the CCRC. Other conditions, including limited direct admissions and spousal admission, may be found at COMAR 10.24.01.03K. It should be noted that although the Commission regulates the development of nursing home beds at CCRCs, the development and financial viability of CCRCs is under the purview of the Maryland Department of Aging.

As illustrated in Table 1 below, both licensed beds and total beds have declined from 2010 to 2018, with fluctuations in CON-approved beds, waiver beds, and temporarily delicensed beds. Overall, total beds have declined about 2 percent during this time period. In 2000, there were 275 nursing homes and 31,004 licensed beds; the figures for 2018 show a 229 nursing homes and 27,329 licensed beds; this represents a decline of nearly 12% in licensed beds between 2000 and 2018.

Table 1: Trends in Nursing Home Beds, Maryland: Selected Years: 2010--2018

Year	# Facilities	Licensed Beds	CON-Approved Beds	Waiver Beds	Temporarily Delicensed Beds	Total Beds
2010	237	27,817	93	373	865	29,148
2013	237	27,575	163	377	637	28,752
2016	234	27,599	249	334	207	28,389
2017	231	27,524	340	342	222	28,428
2018	229	27,329	340	336	447	28,452

Source: MHCC CON Files

Data Collection:

MHCC is also responsible for data collection from nursing homes and other types of long-term care facilities, including assisted living, adult day care, and chronic hospitals. Such data is used for CON review of nursing home projects, bed need projections, and development of the Nursing Home Chapter of the State Health Plan. This data is collected annually via the Maryland Long Term Care Survey and a public use data set is prepared and posted at: http://mhcc.maryland.gov/public_use_files/index.aspx

Consumer Guide to Long Term Care:

Data collected from the annual long term care survey, along with data from OHCQ and other sources, is also used to post information on the MHCC Consumer Guide to Long Term Care. This includes tools for searching for long-term care facilities, making comparisons among providers, such as nursing homes, assisted living, home health agencies, or hospices. There is also information on community resources, as well as how consumers may pay for long term care services: http://mhcc.maryland.gov/consumerinfo/longtermcare/Default.aspx

What are the Recent National Developments in Long-Term Care?

There are many developments in long-term care, at both the federal and state level. Many changes in the delivery system and financing of long-term care services have occurred since the last Nursing Home Chapter of the State Health Plan (COMAR 10.24.08) was adopted in 2007. This background paper will briefly review and update some of these changes on both the national and state level, highlighting possible implications for the future utilization of long-term care services.

IMPACT Act:

The Centers for Medicare and Medicaid Services (CMS) was concerned about post-acute spending which between 2001 and 2013 grew at an annual rate of 6.1 percent and doubled to $59.4 billion. Payments to hospitals grew at an annual rate of 1.7 percent during the same time period. The intended solution to this issue of accelerated post-acute spending was the passage of the IMPACT Act of 2014 legislation.[2]

"The Improving Post-Acute Care Transformation (IMPACT) Act of 2014 mandates the HHS secretary to measure how often certain services should be used in post-acute settings based on the risk of a provider's population. The CMS also proposes evaluating a provider's efficiency by tracking per-beneficiary spending." [3] Field testing for measures began in July 2016. After testing, the use of standardized assessment data is due no later than the following: SNF, Inpatient Rehabilitation Facilities (IRF), Long Term Care Hospitals (LTCH) (October 1, 2018); HHA (January 1, 2019). The March, 2017 MedPAC report recommended changes in reimbursement for all post-acute payer types. They recommend transitioning to a unified post-acute prospective payment system (PPS) beginning as early as 2021. Until then, they recommend that CMS move forward with revisions to SNF and home health PPS.[4]

Bundled Payment:

One component of the IMPACT Act is the development of a demonstration model for bundled payment. The first one is for joint (hip and knee) replacement. Under this model, acute care hospitals in certain selected geographic areas would assume quality and payment responsibility for retrospectively calculated bundled payments for joint replacement episodes. The payment program would make hospitals financially accountable for the cost and quality of all medical services related to lower-joint replacements during a patient's hospital stay and for 90 days after. This program would waive the 3-day hospital requirement prior to a nursing home admission; however, the nursing home used for placement must have at least 3 stars on the CMS' Nursing Home Compare website.[5]

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[2] Dickson, V. "Providers Balk at Post-Acute Measures". _Modern Healthcare_. January 21, 2016
[3] Ibid.
[4] Report to Congress. Medicare Payment Policy. MedPac. March, 2017.
[5] Evans, Melanie. "Bundled Payment Demo has Nursing Homes Seeing Stars". _Modern Healthcare_, November 21, 2015.

It is expected that such programs will encourage collaboration between hospitals and nursing homes since there will be a shared financial incentive to ensure the best care throughout the continuum of care. As of March 2017, CMS has delayed the expansion of the bundled payment for comprehensive care for joint replacement and cardiac care. In November 2017, CMS indicated that it wanted to focus on voluntary models. On January 9, 2018, CMS introduced a test program for bundled payment for 32 clinical episodes; however, this model only includes hospitals and physicians and excludes post-acute providers such as nursing homes and home health agencies.[6]

NOTICE Act:

CMS requires a three-day (acute care) hospital stay prior to patients being able to qualify for Medicare payment for skilled care in a nursing home. Patients in hospitals are often classified under "outpatient observation" even though they spend multiple nights in an acute care hospital. Such patients may be unaware that they were not considered inpatients and were often surprised when confronted with bills at their admission to nursing homes, since they did not qualify for Medicare payment. The Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, as passed in August 2015, requires all acute care hospitals to notify Medicare beneficiaries of their outpatient status within 36 hours of admission. This Act became effective August 2016.

5-Star Ratings Update:

CMS developed the 5-Star Quality Rating system for nursing homes in 2008. This data is posted on CMS' Nursing Home Compare website. It includes three domains: health inspections; staffing; and quality measures. Each domain has its own 5-star rating. There are separate quality measures for long-stay and short-stay patients.

In January 2015, CMS revamped its 5-Star Quality Rating System for nursing homes. Major changes included: nursing homes will have to begin reporting staffing levels quarterly using an electronic system that can be verified with payroll data; a national auditing program aimed at checking quality measures will be initiated.

The new measures resulted in major shifts in scoring. "With nearly one out of every three of the nation's post-acute providers downgraded by the administrative order, the agency and providers now face the task of explaining the ramifications to the public."[7] Further system adjustments, involving hospital readmission rates from nursing homes were implemented during 2016. CMS acknowledged that it was inappropriate to compare the previous 5-star ratings with the current, but suggested that what was expected in 2008 is not what is expected of providers in 2015, since "we expect improvements over time…"[8]

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[6] Reid, Jon. "Post-Acute Care Providers Upset Over Being Left Out of Bundled-Payment Test Program." *Morning Consult,* January 23, 2018.

[7] Myers, B and Oberst, J." Providers React to Changes in five-Star Quality Ratings." *Provider.* April, 2015.

[8] Ibid.

In July 2016, CMS added new measures as follows:

- Percentage of short-stay residents who were successfully discharged to the community;
- Percentage of short-stay residents who have had an outpatient emergency department visit;
- Percentage of short-stay residents who were re-hospitalized after a nursing home admission;
- Percentage of short-stay residents who made improvements in function;
- Percentage of long-stay residents whose ability to move independently worsened.

The first three measures are claims-based; the last two are MDS-based. These measures will be phased in. In July 2016 they will have 50% of the weight of current measures; by January 2017, they will have the same weight as current measures.

Other methodological changes introduced in July 2016 include:

- Using four quarters of data rather than three for determining quality measure (QM) ratings;
- Reducing the minimum denominator for all measures (short-stay, long-stay, and claims-based) to 20 summed across four quarters;
- Revising the imputation methodology for QMs with low denominators meeting specific criteria. A facility's own available data will be used and the state average will be used to reach the minimum denominator;
- Using national cut points for assigning points for the ADL QM rather than state-specific thresholds.[9]

American Health Care Association Quality Initiative

The American Health Care Association (AHCA) has worked to quantify goals in quality of care that are aligned with the CMS Quality Assurance/Performance Improvement (QAPI) program, Five Star Ratings and the IMPACT Act.

For Short-Stay (Post-Acute), these include:

- Safely reduce the number of hospital admissions within 30 days during a skilled nursing stay by an additional 15% or achieve and maintain a low rate of 10% by March, 2018.
- Improve discharge back to the community by 10% or achieve and maintain a high rate of at least 70% by March 2018.

For Long-Term and Dementia Care, these include:

- Safely reduce hospitalizations among long-stay residents by 15% or achieve/maintain a low rate of 10% or less by March, 2018.

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[9] Design for *Nursing Home Compare* Five-Star Quality Rating System: Technical User's Guide, July, 2016.

- Safely reduce the off-label use of antipsychotics in long-stay nursing center residents by 25% by December 2015 and 30% by December 2016. [10]

Medicare Conditions of Participation:

In July 2015, Medicare released draft changes to the Medicare Conditions of Participation for SNFs. This is the first major overhaul of these regulations in 25 years. The first part took effect in November 2016; the rest will be phased in from 2017-2019.

Some of the updates add new definitions (e.g. "person-centered care") and some are administrative shifts. Several new sections include: facility responsibilities (protecting rights of residents and enhancing quality of life); comprehensive person-centered care planning (requires a baseline plan of care within 48 hours; requires interdisciplinary team); requirement for in-person evaluation of residents by physician, physician assistant, nurse practitioner, or clinical nurse specialist before an unscheduled transfer to the hospital; section on behavioral health; requirement for pharmacist review of resident's drug regimen every six months; requirement for disclosure about binding arbitration agreements; enhanced Quality Assurance and Performance Improvement (QAPI) programs; addition of Compliance and Ethics program; requirement that facilities certified after effective date of regulations have no more than two beds per room.

In addition, recent MedPAC recommendations include elimination of market basket updates for SNFs for 2018 and 2019 and a report on revising the prospective payment system for nursing homes by 2020[11]. It should be noted that CMS is not required to follow the recommendations made by MedPAC.

What are the Recent State Developments in Long-Term Care?

Medicaid Reimbursement Methodology:

Since Medicaid is the payer for about 60% of patient days in Maryland's nursing homes, changes in reimbursement have a major effect on how services are delivered. The Maryland Medicaid reimbursement system has been in place since the early 1980s. The revised reimbursement system went into effect January 2015.

The prior system was acuity based and reimbursed for patient care based on four levels: light, moderate, heavy, and heavy special (heavy with add-on services). It was a combination of cost settlement and prospective reimbursement. The new system is a prospective payment system that has one resident care rate that is based on resident acuity calculated quarterly based on minimum data set (MDS) assessments and Resource Utilization Groups (RUG-IV).

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[10] The Quality Initiative 2015-2018,
www.ahcancal.org/quality_improvement/qualityinitiative/Pges/default.aspx/#2

[11] *Provider Magazine*, Long Term and Post-Acute Care, January 13, 2017.

Facility rates still include four cost centers: administrative and routine (e.g., administration, training, housekeeping), other patient care (e.g., pharmacy, social services), capital (e.g., real estate tax, fair rental value), nursing services (all direct care). In addition, days of service are paid in full at the time of the claim; that is, there is no cost settlement.

Some of the previous add-ons were consolidated into the resident care day rate; others remain. There is a ventilator care day rate, one separate per diem based on high acuity. Other add-ons include: class A and B support services (special mattress as a pressure reducing surface), bariatric beds, power wheel chairs, and negative pressure wound therapy.

Licensing Regulations:

The Office of Health Care Quality (OHCQ) is in the process of updating the licensure regulations governing comprehensive care facilities (COMAR 10.07.02). To date, there have been several versions of updates from 2014 through 2015, with the latest (Version 5) being November 14, 2016. These regulations are currently in the promulgation process, but have not yet been proposed or adopted.

Changes were proposed in the draft regulations in several areas. In the definitions section, new definitions and/or changes are made for: certified dietary manager; chemical restraints; comprehensive care facility; culture change facility; extended care facility; geriatric nursing assistant; infection preventionist; types of licensed social workers; nursing home; physical restraint; protective device; minimum data set, and others.

There is draft language stating that the Department will make a site visit and conduct a full survey of each licensed nursing home every year. There is new draft language on development of new facilities, including approval by architects and by MHCC. Language is added on written policies for admission and discharge, including whether the facility accepts Medicaid and how to apply for Medicaid.

The section on Nursing Services includes draft revisions. This includes policies and procedures, coordination with other disciplines, and staffing. The ratio of staff to residents remains the same, but the requirements change from "sufficient staff to provide a minimum of two hours of bedside care per occupied bed, seven days per week" to three hours of bedside care.

In addition to the current special care unit-general and special care unit-respiratory, there is the draft language addition of special care unit-dementia care. There is also a new draft section added on Electronic Health Records.

Nursing care units can still be up to 60 beds. The draft regulations also specify that "no more than four individuals may occupy a multiple occupancy bedroom."

Money Follows the Person:

Money Follows the Person (MFP) is a federal Medicaid program designed to move elderly nursing home residents out of nursing homes and back into their own homes or into the homes of their loved ones. In some states, the program also extends to help persons in immediate risk of nursing home placement.

The MFP program does not provide individuals with financial grants to aid in their transition. Instead this is a federal program that provides states with grants so they can develop Money Follows the Person programs. These programs use existing Medicaid resources such as home and community-based waivers to assist individuals in managing their care outside of a nursing home. The federal funds are also put toward the development of new services designed to help individuals with the transition such as housing coordination, case management and tele-health services.

MFP, first authorized in the Deficit Reduction Act of 2005, was extended to 2016 under the Affordable Care Act. To be eligible, Medicaid beneficiaries must reside in an institution (nursing home, ICF-MR) for at least 90 days prior to transitioning to a community site (e.g. house, apartment, small group home, assisted living). Under MFP, a participant receives home and community-based services for which the state receives enhanced federal matching funds.[12]

The Maryland plan includes multiple waiver programs serving several types of individuals:

- The Home and Community-Based Options Waiver (CO) serves individuals 18 and older providing case management, assisted living, and family training.

- The Brain Injury (BI) Waiver serves adults with brain injuries and provides day habilitation, family and individual support services, supported employment, and residential rehabilitation.

- The Community Pathways (CP) Waiver serves adults with developmental disabilities and provides personal supports, case management, day habilitation, environmental modifications, and other services.

- The Community First Choice (CFC) program offers personal assistance services, nurse monitoring, personal emergency response systems, transition services, home delivered meals, and other services. [13]

Since March 2008, Maryland has transitioned over 1,900 Medicaid beneficiaries from institutions to community settings through the MFP demonstration. The total MFP grant funding awarded to Maryland from 2007 to date is $86.3 million which runs through September 2016. Some of these populations are in nursing homes and others are in other types of institutions. Medicaid also offers a brochure entitled "Get Long Term Services and Supports in the Community!" This offers resources and phone numbers for consumers.[14]

The Hilltop Institute conducted an evaluation of Maryland's Money Follows the Person program. Overall, results indicated that Medicaid costs declined after individuals transitioned to the

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[12] Watts, Molly O'Malley and Reaves, Erica L. "Maryland's Money Follows the Person Demonstration: Support Transitions through Enhanced Services and Technology." KFF Issue Brief April 25, 2014.
[13] "Maryland MFP Sustainability Plan" (draft) March 30, 2015.
[14] https://mmcp.health.maryland.gov/longtermcare/SiteAssets/SitePages/Nursing%20Home%20Services/MFI-Living%20in%20the%20Community%20Flyer-2014.pdf

community. They also found that a higher percentage of transitioned individuals reported higher quality of life.[15]

All-Payer Model:

Maryland initiated a new all-payer model for regulation of hospital charges in 2014. It transitioned the 40-year old system of regulation from a Medicare inpatient per admission test to an all-payer total hospital payment model, with spending growth limitations and Medicare savings targets. This model has met the objectives agreed to by Maryland and CMS to date and, in 2020, is planned to enter a second phase model expanded to address the total cost of care, across the continuum of primary care, outpatient diagnosis and treatment, inpatient care, and post-acute and long-term care. The spending limitations and savings targets that will be adopted for this second phase model will reinforce the Phase One emphasis on reducing hospital admissions and readmissions and broadening the scope to post-acute care, incentivizing reductions in Medicare skilled nursing facility admissions and length of stay.

According to the *Maryland All-Payer Model Progression Plan*, a key element going forward will be to develop initiatives focused on post-acute and long-term care. The report acknowledges that "currently, there is little comprehensive care coordination between settings that address the needs of these patients who have higher rates of potentially avoidable [hospital] utilization." The goals are to coordinate and optimize the use of acute care hospital services with post-acute and nursing home services. Options that may be considered include bundled payments and controlled relaxation of the three-day rule which requires a three day hospital stay prior to nursing home admission for Medicare patients.[16]

Use of Quality Measures:

Quality has become an increasing focus for many Medicare programs, including nursing homes, as discussed above. These quality measures are reported on the national Nursing Home Compare website, as well as the Commission's Consumer Guide to Long Term Care Services: http://mhcc.maryland.gov/consumerinfo/longtermcare/Default.aspx

Quality measures are also a part of OHCQ's Pay for Performance system. Legislation was passed to authorize OHCQ to establish a health care quality account in the Maryland Department of Health. This account is funded by civil money penalties paid by nursing homes. A portion of the revenue generated can be distributed to nursing homes based on accountability measures, a Pay for Performance or P4P model. Ratings are established as follows:

- MHCC Family Satisfaction Survey (40%)
- Staffing levels and staff stability in nursing facilities (40%)
- MDS Quality Indicators (16%)

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[15] Fox-Grage, Wendy. "State Studies Find Home and Community-Based Services to be Cost-Effective." AARP Public Policy Institute, March 2013.

[16] *Medicare All-Payer Model Progression Plan*, December 16, 2016.

- Employment of Infection Control Professional (2%)
- Staff Immunizations (2%)

Under this model, the highest scoring facilities -- representing 35% of the eligible days of care -- receive a quality incentive payment. [17]

Quality measures will also be an important component of CMS's push towards Value Based Purchasing for many services, including nursing homes. In 2009, CMS Innovations Center began a demonstration of Value Based Purchasing in three states: Arizona, New York, and Wisconsin. In the demonstration performance is based on 4 domains: staffing, hospitalizations, MDS outcomes, and survey deficiencies. The points are totaled to produce an overall quality score. Nursing homes with a score in the top 20% and homes that are in the top 20% in terms of improved scores will be eligible for the State's savings pool.[18]

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[17] Tucker, Susan, DHMH Memorandum, October 5, 2015.
[18] CMS Innovations Center: https://innovation.cms.gov/initiatives/Nursing-Home-Value-Based-Purchasing/

What are the Issues in Long Term Care Planning?

Given the changes, on both the federal and state levels, in long term care and nursing home services, there is a need to update the Nursing Home Chapter of the State Health Plan. Some of these issues include the following:

Nursing homes in the continuum of care:

- How do nursing homes reduce their length of stay and refer residents to appropriate community-based services?
- What is the role of nursing homes and how has it changed over time?
- How have staffing needs changed?
- How can nursing homes partner with hospitals in order to reduce 30-day readmissions?

Focus on quality:

- How can quality measures and standards be specified and applied to ensure the best quality care for Maryland residents?
- How should quality measures be incorporated into CON reviews?
- How can consumer choice be ensured via the MHCC Consumer Guide for Long Term Care Services?

Innovative Design:

- How can nursing homes be encouraged, in both new facilities and renovations, to develop designs that move away from an institutional model of care?
- How can nursing homes incorporate principles of person-centered care?
- How can nursing homes meet medical needs, while offering a homelike environment?
- How can nursing home design be revised consistent with the Facility Guidelines Institute (FGI) Guidelines?

Nursing home need projections:

- How can the nursing home bed need be simplified so that it is easily replicated and updated?
- How can need be updated with fewer adjustment steps?
- How can bed need be tied to jurisdictional occupancy?